

## GENERAL APPENDIX 10

### PROVIDER FORMS REQUEST INSTRUCTIONS

The Department of Healthcare and Family Services (HFS) provides required billing forms (with the exception of the UB-92 claim form), prior approval request forms, adjustment forms and various types of pre-addressed mailing envelopes to be used by the providers to submit claims and adjustments to the Department. Single sheet billing forms are intended for use only in laser printers. Multi-page continuous feed forms are intended for use in either typewriters or impact printers.

These materials may only be obtained by submitting Form HFS 1517/1517A, Provider Forms Request, to the Department as described below. The Department will not mail forms (except Form HFS 1517/1517A) in response to telephone requests. Local Department of Human Services offices do not maintain a supply. The provider should submit the Provider Forms Request at least three weeks in advance.

#### PREPARATION AND MAILING INSTRUCTIONS FORM HFS 1517/1517A, PROVIDER FORMS REQUEST

Facsimiles of Form HFS 1517 and 1517A are included in this Appendix. Instructions for their completion follow in the order in which the entry fields appear on the form. The forms should be either typewritten or legibly hand printed.

**Provider Name, Provider Number, and Provider Type** - Enter the provider name, provider number and provider type exactly as they appear on the Provider Information Sheet.

**HFS Form Number and Quantity** - Enter the HFS form number(s) being requested. Generally, the form number is shown in the lower left corner of the form. In most cases, the form number format will be "HFS" followed by a number or number/alphabetical combination.

Enter the quantity of each form requested. The quantity should be in lots of 100, i.e., 100, 200, 500, etc. Please request a sufficient quantity to last three (3) months. If applicable, indicate whether the forms are to be either Continuous Feed or Snap Out.

**HFS Envelope Number and Quantity** - Enter the HFS envelope number being requested. The number of the envelope is shown in the lower left corner on the face of the envelope. Enter the quantity of the envelope requested. Please request a sufficient quantity to last three (3) months.

Refer to Chapter 200 of the applicable provider Handbook for the form and envelope numbers appropriate for each provider type.

**Mailing Label Area (bottom of the form)**

Enter the name and address to which forms and envelopes are to be sent. Inclusion of the zip code is essential. Forms and mailing envelopes will be sent only to enrolled providers. HFS will not provide forms or envelopes to a billing service, unless the order includes the name and provider number of a currently enrolled medical provider on whose behalf the billing service is requesting forms.

**SUBMITTAL INSTRUCTIONS**

Submit the original Provider Forms Request as follows:

For the counties of Cook, DuPage, Kane, Kankakee, Lake, Will and Winnebago send a Form HFS 1517A to:

Illinois Department of Healthcare and Family Services  
5150 West Roosevelt Road  
Chicago, Illinois 60644-1437

For all other Illinois counties and all out-of-state providers, send a Form HFS 1517 to:

Illinois Department of Healthcare and Family Services  
Medical Desk, HFS Warehouse  
2946 Old Rochester Road  
Springfield, Illinois 62703-5659

Online ordering can be done at <[www.hfs.illinois.gov/forms/](http://www.hfs.illinois.gov/forms/)>.

## Reduced Facsimile of Form HFS 1517



Illinois Department of Healthcare and Family Services  
 2946 Old Rochester Road  
 Springfield, Illinois 62703-5659  
 Fax Number: (217) 557-6800

**PROVIDER FORMS REQUEST**

Completion of this form or compliance with instructions is voluntary. However, failure to do so may affect this Department's action on this request. This form approved by the Forms Management Center.

Submit this form either by E-Mail, Fax or mail to the address listed above.

Please limit the quantity of forms and envelopes requested to an amount which would be used in a 3 month period.

**TYPE OR PRINT ALL ENTRIES**

ORDER REQUEST DATE: \_\_\_\_\_ PROVIDER MEDICAID NUMBER: \_\_\_\_\_

PROVIDER NAME: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ **(CANNOT DELIVER TO POST OFFICE BOX)**


CITY/STATE/ZIP: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ ATTENTION OF: \_\_\_\_\_

PROVIDER E-MAIL ADDRESS: \_\_\_\_\_ (Optional)

Enter the quantity of the forms being requested. When ordering your 3-month supply, please be sure to indicate the total number of individual forms or envelopes needed in the Quantity column, not the number of boxes, cases or packages.

<b><u>HFS Form Number:</u></b>	<b><u>QUANTITY:</u></b>	<b><u>Envelope Number:</u></b>	<b><u>QUANTITY:</u></b>
215CF Drug Invoice, (Continuous Feed Format)	_____	824MCR Medicare Crossover	_____
1409 Prior Approval Request	_____	1414 Special Approval	_____
1443 Provider Invoice, (Single Sheet)	_____	1415 Drug Invoice	_____
1443CF Provider Invoice, (Continuous Feed Format)	_____	1416 Adjustments	_____
2209 Transportation Invoice, (Single Sheet)	_____	1444 Provider Invoice Envelope	_____
2209CF Transportation Invoice, (Continuous Feed Format)	_____	2244 Transportation Invoice	_____
2210 Medical Equipment / Supplies Invoice, (Single Sheet)	_____	2246 Health Agency Invoice	_____
2210CF Medical Equipment / Supplies Invoice, (Cont. Feed Format)	_____	2247 Medical Equipment Supplies	_____
2211 Laboratory / Portable X-Ray Invoice, (Single Sheet)	_____	2248 NIPS Special Invoice Handling	_____
2211CF Laboratory / Portable X-Ray Invoice, (Cont. Feed Format)	_____	2294 Equip/Supplies Prior Approval	_____
2212 Health Agency Invoice, (Single Sheet)	_____	2300 Prior Approval Request	_____
2212CF Health Agency Invoice, (Continuous Feed Format)	_____	<b><u>Additional Forms Needed, Not Listed Above:</u></b>	
2360 Health Insurance Claim Form, (Single Sheet)	_____	_____	_____
2360CF Health Insurance Claim Form, (Continuous Feed Format)	_____	_____	_____
3797 Medicare Crossover Invoice (Single Sheet)	_____	_____	_____
3797CF Medicare Crossover Invoice, (Continuous Feed Format)	_____	_____	_____

## Reduced Facsimile of Form HFS 1517A

PROVIDER FORMS REQUEST																											
<div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="text-align: center;">  </div> <div> <b>Illinois Department of Healthcare and Family Services</b>  <b>5150 West Roosevelt Road</b>  <b>Chicago, Illinois 60644-1437</b>  <b>Fax: (773) 854-5174</b> </div> </div> <p>Completion of this form or compliance with instructions is voluntary. However, failure to do so may affect this Department's action on this request. This form approved by the Forms Management Center</p> <p>Please limit the quantity of forms and envelopes requested to an amount which would be used in a 3 month period.</p> <p><b>TYPE OR PRINT ALL ENTRIES</b></p> <p>ORDER REQUEST DATE _____</p> <p>PROVIDER NAME _____</p> <p>PROVIDER NUMBER _____ PROVIDER TYPE _____</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%; text-align: left; padding: 5px;">Enter below the "HFS Form Number" And "Quantity" requested.</th> <th style="width: 50%; text-align: left; padding: 5px;">FOR HFS USE ONLY</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;"> <table style="width: 100%;"> <tr> <th style="text-align: left; width: 40%;"><u>HFS Form Number</u></th> <th style="text-align: left;"><u>QUANTITY</u></th> </tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </table> </td> <td rowspan="2"></td> </tr> <tr> <td style="padding: 5px;"> <p>Enter below the "HFS Envelope Number" And "Quantity" requested.</p> <table style="width: 100%;"> <tr> <th style="text-align: left; width: 40%;"><u>HFS Envelope Number</u></th> <th style="text-align: left;"><u>QUANTITY</u></th> </tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </table> </td> </tr> </tbody> </table> <p>(Provider Number is Required)</p> <p>PROVIDER NUMBER _____ PROVIDER TYPE _____</p> <p>_____</p> <p><i>Attention</i> _____</p> <p><b>PROVIDER NAME</b> _____</p> <p>_____</p> <p><i>Street Address (cannot deliver to Post Office box)</i> _____</p> <p>City _____ State _____ Zip _____</p> <p>HFS 1517A (R-9-05) <span style="float: right;">IL478-1023</span></p>			Enter below the "HFS Form Number" And "Quantity" requested.	FOR HFS USE ONLY	<table style="width: 100%;"> <tr> <th style="text-align: left; width: 40%;"><u>HFS Form Number</u></th> <th style="text-align: left;"><u>QUANTITY</u></th> </tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </table>	<u>HFS Form Number</u>	<u>QUANTITY</u>	_____	_____	_____	_____	_____	_____	_____	_____		<p>Enter below the "HFS Envelope Number" And "Quantity" requested.</p> <table style="width: 100%;"> <tr> <th style="text-align: left; width: 40%;"><u>HFS Envelope Number</u></th> <th style="text-align: left;"><u>QUANTITY</u></th> </tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </table>	<u>HFS Envelope Number</u>	<u>QUANTITY</u>	_____	_____	_____	_____	_____	_____	_____	_____
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## **GENERAL APPENDIX 11**

### **MANAGED CARE ORGANIZATION (MCO) CONTRACTORS**

#### **COOK COUNTY**

##### **Harmony Health Plan**

125 South Wacker Drive, Suite 2600  
Chicago, Illinois 60606  
Telephone (312) 630-2025  
Fax (312) 368-1784  
Member Services (800) 608-8158

##### **Family Health Network**

910 West Van Buren, 6<sup>th</sup> Floor  
Chicago, Illinois 60607  
Telephone (312) 491-1956  
Fax (312) 491-1175  
Member Services (888) 346-4968

#### **MADISON, PERRY, RANDOLPH, ST. CLAIR AND WASHINGTON COUNTIES**

##### **Harmony Health Plan**

23 Public Square, Suite 340  
Belleville, Illinois 62220  
Telephone (618) 236-8050  
Fax (618) 233-3621  
Member Services (800) 608-8158